

## Health Information Management/Medical Records Department Authorization for Release of Medical Records

	Medical Record #		
Patient's Name			
Last	First	DOB	SS#
		Phone#	
treet City	State Apt#	Zip	Home Cell
or my authorized representative, request that health with New York State Law and the Privacy Rule of the H. This authorization may include disclosure of information psychotherapy notes, and CONFIDENTIAL HIV R authorize release of such information to the per I. If I am authorizing the release of HIV-related, along from redisclosing such information without my aright to request a list of people who may receive because of the release or disclosure of HIV-relation or the New York City Commission of Human Right. Information disclosed under this authorization in longer be protected by federal or state law.  I have the right to revoke this authorization at an authorization except to the extent that action has a lunderstand that signing this authorization is volumed. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU.	Health Insurance Portability a primation relating to ALCOH- ELATED INFORMATION. Or son(s) indicated below. It is considered below. It is is the primate or use my HIV-related information. I may control at (212) 306-7450. The snight be redisclosed by the my time by writing to the heas already been taken based luntary.	nd Accountability Act of 1996 (HIP OL AND DRUG ABUSE, MENTAL ally if I place my initials on the appearance of the place of	PAA), I understand that:  HEALTH TREATMENT, except opportunities line, I specifically thation, the recipient is prohibited ate law. I understand that I have the If I experience discrimination of Human Rights at (212) 480-2493 rotecting my rights.  e) and this redisclosure may no  I understand that I may revoke this
HEREBY AUTHORIZE AND REQUEST <u>BR</u> Brookdale Plaza, Brooklyn NY 11212,			
DATE OF TREATMENT: from:	through:	PURPOSE:	
Medical Records:	_		
•	ch, H&P, progress notes, co	nsultations, procedure test resul	,
Consultation(s):		Clinic Records	Immunization Records
Ancillary Test Results	Other		
		(Specify)	
Pologgo to:			
Release to:(Print Na	ame)	Fax No.:	
(i mene	mic)		
Street	City	State	Zip Apt/Suite #
Initial AUTHORIZATION FOR RELEASE OF AUTHORIZATION FOR RELEASE OF Initial INFORMATION PER NYS L 2782, 27	CONFIDENTIAL HUMAN I		
Print Name			
Patient/Legal Guar	rdian/Distributee		
, ,	•		
Signature			
Patient/Legal Guardian/Dist	ribute authorized by law	Date Au	thority to sign on behalf of patient
Date on which this authorization will expire (one	e year after the date of sig	nature) <b>unless</b> otherwise spe	cified by me
RECORDS WILL BE RELEASED ONLY WI			-
Photo ID with signature (attach			ath Certificate (attach copies)

(records of deceased patient)

Intaker's Initials